HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
DIVISION OF INVESTIGATION
P.O.BOX 95164
LINCOLN, NEBRASKA 68509-5164

REPORT BY HEALTH FACILITIES, PEER REVIEW ORGANIZATIONS

AND PROFESSIONAL ASSOCIATIONS

Section 1: REPORTING ENTITY - Check one.

Report is being made by:

☐ Health Facility
☐ Peer Review Organization
☐ Professional Association

Name of Reporting Entity: _____

Address: _____

_____

Telephone No: _____

Section 2: IDENTIFYING INFORMATION - Complete all items for the person being reported if information requested is known.

Name: _____ Work Telephone No: _____
(First) (M.I.) (Last)

Nebraska License No: _____

Work Address: _____

License Field: _____

_____
(City) (State) (Zip)

Social Security No: _____ Date of Birth: _____
(OPTIONAL- see back for instructions)

Section 3: ACTION BEING REPORTED - Complete all items in Parts A or B that apply. If additional space is needed, please attach pages to this form.

Part A - Payments

1. The payment was made due to:

   a. ☐ Adverse Judgment
   b. ☐ Settlement
   c. ☐ Award

2. Describe the act(s), omission(s), or other conduct that gave rise to the claim:

3. Enter the following information:

   a. Date of Judgment, Settlement or Award: _____
   b. Payment Date: _____
   c. Payment Amount: $ _____
   d. Payment terms and conditions, if any:

4. State where the act(s), omission(s), or conduct occurred:

   Location Name: _____

   Address: _____

   _____

   Telephone No: _____

5. Describe how the act(s), omission(s), or conduct occurred:

6. Describe any injury, illness, damage, or other loss or detriment that resulted in the payment being made:

7. List all patients, clients, or other persons to whom or for whose behalf payment was made:

Name	Address

8. List all persons who were present at the time of the act(s), omission(s), or conduct which resulted in a payment and who would have firsthand knowledge of the same:

Name	Title	Address	Telephone #

9. When payment results from a court action or claim having been filed with a court or other adjudicative body, complete the following items:

   a. Name of court or adjudicative body: _____

   b. Address: _____

      _____

   c. Case No: _____

Part B - Adverse Action affecting Privileges at a Health Care Facility or Membership in a Professional Association

1. The adverse action was taken due to alleged:

   a. ☐ Incompetence
   b. ☐ Professional Negligence
   c. ☐ Unprofessional Conduct
   d. ☐ Impairment: ☐ Mental ☐ Physical ☐ Chemical

2. Indicate the type of adverse action taken:

Privileges	Membership
a. ☐ Privileges Denied	a. ☐ Membership Denied
b. ☐ Privileges Limited	b. ☐ Membership Terminated
c. ☐ Privileges Reduced	c. ☐ Membership Renewal Refused
d. ☐ Privileges Suspended	d. ☐ Other (Specify): _____
e. ☐ Privileges Revoked	
f. ☐ Other (Specify): _____	

3. Describe the act(s), omission(s), or conduct which lead to the adverse action against the privileges or membership:

4. Enter the date(s) of the action: _____; effective date: _____; and duration of the action: _____.

5. Specify where the act(s), omission(s), or conduct leading to action occurred:

   Location Name: _____

   Address: _____

   _____

   Telephone No: _____

6. Describe how the act(s), omission(s), or conduct occurred:

7. Describe any injury, illness, damage, or other loss or detriment which formed the basis for action affecting privileges or membership:

8. List all persons who were present at the time of the act(s), omission(s), or conduct which resulted in an action affecting privileges or membership and who would have firsthand knowledge of the same:

Name	Title	Address	Telephone #

9. When action affecting privileges or membership results from a court action or claim having been filed with a court or other adjudicative body, complete the following items:

a. Name of court or adjudicative body: _____

b. Address: _____

_____

c. Case No: _____ Judgment or Order, if any: _____

Section 4: REPORTING ENTITY - Complete all items.

Name of person completing report:

Name: _____ Title: _____
(First) (M.I.) (Last)

Address: _____

_____

_____ _____
(Signature) (Date)

Instructions for reporting social security number:

Disclosure of the social security number should be made only if obtained by you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary and failure to provide the number will not subject you to penalty. The purpose for the request is to assist in distinguishing between persons who have the same or similar names for the Department's recordkeeping and implementation of Neb. Rev. Stat. ∋71-168, 71-168.02, 71-1,198 to 71-1,205, and 172 NAC 5, which requires you to file a report with the Department concerning health care professionals when certain actions or events occur. The report you file is subject to review by the applicable licensing board and Department and Attorney General staffs for purposes of enforcement of Nebraska licensing laws. Information is otherwise confidential and made available only according to Neb. Rev. Stat. ∋71-168.01 in the same manner as complaints and investigative files of the Department or as may otherwise be provided by law.